

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00729**

745

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond (rural) c. LENGTH OF STAY IN 1b Baltimore 4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1201 Purdy Court		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 4 d. STREET ADDRESS 1201 Purdy Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KARL Middle ARON Last ARON		4. DATE OF DEATH Month January Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1925
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 33 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Test Pilot		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert William Aron		14. MOTHER'S MAIDEN NAME MARGARET SCHENK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 353 18 6122	
17. INFORMANT Thomas A. Brant		Address Kingville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 863x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 863x DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 863x			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 11:55 a.m. 1/14 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Nr. Still Pond Kent Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan. 17, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE JAN 19 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. NAME OF DECEASED
2. SEX
3. AGE

4. PLACE OF BIRTH
5. DATE OF BIRTH

6. OCCUPATION
7. MARITAL STATUS

8. PRESENT ADDRESS
9. DATE OF DEATH

10. CAUSE OF DEATH
11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF EXAMINER

14. DATE OF EXAMINATION
15. PLACE OF EXAMINATION

16. SIGNATURE OF DECEASED
17. SIGNATURE OF NEXT OF KIN

18. SIGNATURE OF WITNESSES
19. SIGNATURE OF CLERK

20. SIGNATURE OF JUDGE
21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CORONER
23. SIGNATURE OF JURY

24. SIGNATURE OF GRAND JURY
25. SIGNATURE OF DISTRICT ATTORNEY

26. SIGNATURE OF COUNTY CLERK
27. SIGNATURE OF TOWNSHIP CLERK

28. SIGNATURE OF VILLAGE CLERK
29. SIGNATURE OF CITY CLERK

30. SIGNATURE OF STATE CLERK
31. SIGNATURE OF FEDERAL CLERK

32. SIGNATURE OF POSTAL CLERK
33. SIGNATURE OF MARINE CLERK

34. SIGNATURE OF AIR FORCE CLERK
35. SIGNATURE OF NAVY CLERK

36. SIGNATURE OF COAST GUARD CLERK
37. SIGNATURE OF CUSTOMS CLERK

38. SIGNATURE OF EXCISE CLERK
39. SIGNATURE OF REVENUE CLERK

40. SIGNATURE OF TREASURY CLERK
41. SIGNATURE OF POST OFFICE CLERK

42. SIGNATURE OF RAILROAD CLERK
43. SIGNATURE OF STEAMSHIP CLERK

44. SIGNATURE OF AIRLINE CLERK
45. SIGNATURE OF MARITIME CLERK

46. SIGNATURE OF PORT CLERK
47. SIGNATURE OF SHIP CLERK

48. SIGNATURE OF COAST CLERK
49. SIGNATURE OF NAVY CLERK

50. SIGNATURE OF AIR FORCE CLERK
51. SIGNATURE OF MARINE CLERK

52. SIGNATURE OF COAST GUARD CLERK
53. SIGNATURE OF CUSTOMS CLERK

54. SIGNATURE OF EXCISE CLERK
55. SIGNATURE OF REVENUE CLERK

56. SIGNATURE OF TREASURY CLERK
57. SIGNATURE OF POST OFFICE CLERK

58. SIGNATURE OF RAILROAD CLERK
59. SIGNATURE OF STEAMSHIP CLERK

60. SIGNATURE OF AIRLINE CLERK
61. SIGNATURE OF MARITIME CLERK

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

746

CERTIFICATE OF DEATH

00730

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RFD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home Broad Neck		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Emily Berry		4. DATE OF DEATH Jan. 9, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown Moger		14. MOTHER'S MAIDEN NAME unknown Moger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-9638	
17. INFORMANT John Raymond and Berry		Address Sons Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular DUE TO (c) Arterio Sclerosis - secondary, chronic		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1956 , to Jan 9, 1959 , that I last saw the deceased alive on Jan 9, 1959 , and that death occurred at 8:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norbert C. Nitsch		ADDRESS (Street, city or town, state) Rock Hall, Maryland	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch		DATE SIGNED 1/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/59	
22c. NAME OF CEMETERY OR CREMATORY Chestertown Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE JAN 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hesse	

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CERTIFICATE OF DEATH

Reg. Dist. No. 00731

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chestertown (RFD Georgetown)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home RFD</u>		/ d. STREET ADDRESS <u>RFD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u></u> Last <u>Briscoe</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 1, 1888</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Kent CO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Russell</u>		14. MOTHER'S MAIDEN NAME <u>Anna Washington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease (to my knowledge)</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>41 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of left breast with metastases</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>58</u> , to <u>Jan. 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>59</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>Jan. 19, 1959</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D.			
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>RFD Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>		ADDRESS <u>Chestertown, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-10-1910

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RFD				c. LENGTH OF STAY IN 1b X Chestertown RFD			
d. NAME OF HOSPITAL (If not in hospital, give street address) Kent and Queen Anne's Hospital				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cynthia Middle Brown Last Brown				4. DATE OF DEATH Month Jan. Day 30 Year 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23, 1958	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months 2 Days 7		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George H. Brown				14. MOTHER'S MAIDEN NAME Mildred Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mildred Brown Address Georgetown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition and severe dehydration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vomiting & Diarrhea DUE TO (c) Pneumonia						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-25-59 , 19 59 , to 1-30-59 , 19 59 , that I last saw the deceased alive on 1-30-59 , 19 59 , and that death occurred at 12:35 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1-31-59							
ACTUAL SIGNATURE Harry Paul Ross M.D.							
PHYSICIAN'S NAME (Type) 203 N. Queen Street, Chestertown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/59		22c. NAME OF CEMETERY OR CREMATORY Georgetown, xx. Cem.		22d. LOCATION (City, town, or county) (State) Chestertown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR FEB 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 Calvert St.				d. STREET ADDRESS 1400 Calvert St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harriett Middle M. Last Brown				4. DATE OF DEATH Month Jan. Day 22 Year 1959			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. T. Murray				14. MOTHER'S MAIDEN NAME Henrietta Graves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Elizabeth Black Address 400 Calvert St. Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 334X DUE TO Cerebral Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH one month many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May XXXXXX , 19 58 , to Jan. 22 , 19 59 , that I last saw the deceased alive on Jan. 22 , 19 59 , and that death occurred at 5 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, Md.		ADDRESS (Street, city or town, state) 1/23/59		DATE SIGNED 1/23/59	
PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY James Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Knead	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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CERTIFICATE OF DEATH

00734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE 17x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT & Q.A. HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM C CAREY</u>		4. DATE OF DEATH Month Day Year <u>JAN 9 19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 21-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>GREENSBORO MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wm. Carey</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET PINDER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>HOSPITAL CHART</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF PROSTATE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-7</u> , 19 <u>58</u> , to <u>1-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-8</u> , 19 <u>59</u> , and that death occurred at <u>8</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN</u> DATE SIGNED <u>1-9-59</u>			
ACTUAL SIGNATURE <u>G. J. [Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, JR. MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensteele Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greensteele Cemetery Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. [Signature]</u> ADDRESS <u>Baltimore Md</u>		24a. REC'D BY REGISTRAR <u>AN 1 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. [Signature]</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

80336

1918

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF REGISTRAR</p> <p>11. SIGNATURE OF DECEASED</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF MINISTER OF THE GOSPEL</p> <p>14. SIGNATURE OF CLERGYMAN</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF SURGEON</p> <p>17. SIGNATURE OF JUDGE</p> <p>18. SIGNATURE OF CLERK</p> <p>19. SIGNATURE OF NOTARY</p> <p>20. SIGNATURE OF OTHER</p>	
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740

CERTIFICATE OF DEATH

00735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Edmund Cook, Jr		4. DATE OF DEATH Month Day Year Jan 1 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard Edmond Cook		14. MOTHER'S MAIDEN NAME June Bell Everett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Mother & Hospital records, Chestertown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal atalectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (Duration of pregnancy--28-29 weeks) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 31, 1958 , to Jan 1, 1959 , that I last saw the deceased alive on Jan 1, 1959 , and that death occurred at 11:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr, M.D.		DATE SIGNED Jan 1, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/4/59	22c. NAME OF CEMETERY OR CREMATORY SUDLERSVILLE CEM.	22d. LOCATION (City, town, or county) (State) SUDLERSVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.		24a. REC'D BY REGISTRAR DATE JAN 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

742
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u> 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT & QUEEN ANNES' HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>Gratitude Point</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>EATON</u> Last <u>EATON</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 27, 1868</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANTHONY HEWES</u> Hughes				14. MOTHER'S MAIDEN NAME <u>MARY DAVIES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition & Dehydration</u> 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Age</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Rock Hall Md.</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 12</u> , 19 <u>58</u> , to <u>Jan 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>59</u> , and that death occurred at <u>11:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William M. Gatewood</u>				DATE SIGNED <u>1/13/59</u>			
PHYSICIAN'S NAME (Type) <u>William M. Gatewood</u>				ADDRESS (Street, city or town, state) <u>Rock Hall Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF CHIEF CLERK</p>		<p>18. SIGNATURE OF ASSISTANT CLERK</p>		<p>19. SIGNATURE OF DEPUTY CLERK</p>		<p>20. SIGNATURE OF DEPUTY ASSISTANT CLERK</p>	
<p>21. SIGNATURE OF DEPUTY DEPUTY CLERK</p>		<p>22. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK</p>		<p>23. SIGNATURE OF DEPUTY DEPUTY DEPUTY CLERK</p>		<p>24. SIGNATURE OF DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p>		<p>25. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY CLERK</p>	
<p>26. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p>		<p>27. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK</p>		<p>28. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p>		<p>29. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY CLERK</p>		<p>30. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p>	

1860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00737

742 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 45 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		d. STREET ADDRESS 66 North Clifton Avenue	
3. NAME OF DECEASED (Type or print) John Robert Elliott		4. DATE OF DEATH Month January Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Phila Elec. Company	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Elliott		14. MOTHER'S MAIDEN NAME Adelaide Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 181 10 4047	
17. INFORMANT Edward Elliott(son)		Address 206 Cowbell Rd, Willow Grove Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO History of several attacks of acute coronary insufficiency, with pulmonary edema in past three years.			INTERVAL BETWEEN ONSET AND DEATH 90 minutes Don't know
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/11
20f. (City or town) 11/11		(County) (State)	
21. I certify that I attended the deceased from 1/11 , 19 59 , to 1/11 , 19 59 , that I last saw the deceased alive on 1/11 , 19 59 , and that death occurred at 11:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/11/59			
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	22d. LOCATION (City, town, or county) (State) Yeadon - Dela. Co. Penna
23. FUNERAL DIRECTOR'S SIGNATURE William Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR Jan 13 59		24b. REGISTRAR'S SIGNATURE Charles E. Hanks	

CERTIFICATE OF DEATH

323

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JOHN J. SMITH		JANUARY 15, 1924		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
45		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JANUARY 1, 1879		BALTIMORE, MARYLAND		UNITED STATES	
MARRIAGE		EDUCATION		OCCUPATION	
MARRIED		HIGH SCHOOL		LABORER	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
JANUARY 1, 1900		BALTIMORE, MARYLAND		UNITED STATES	
PREVIOUS DEATHS		CAUSE OF DEATH		MANNER OF DEATH	
None		HEART DISEASE		NATURAL	
DATE OF BURIAL		PLACE OF BURIAL		CITY OF DEATH	
JANUARY 18, 1924		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN	
JOHN J. SMITH & SONS		JOHN J. SMITH		JOHN J. SMITH	
ADDRESS OF FUNERAL HOME		ADDRESS OF MINISTER		ADDRESS OF CLERGYMAN	
1234 BALTIMORE ST.		1234 BALTIMORE ST.		1234 BALTIMORE ST.	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF THIS CERTIFICATE		NAME OF REGISTRAR		NAME OF CLERK	
JANUARY 15, 1924		JOHN J. SMITH		JOHN J. SMITH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00738

748

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Betterton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Betterton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Howard</u> Last <u>Hahn</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1895</u>		9. AGE (In years lost birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Marine</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Hahn</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Hildebrandt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>178-18-4224</u>		17. INFORMANT Address <u>Mrs. Anne Volker Betterton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pleural effusion + asthma</u> (c) <u>arteriosclerosis, generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>8 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic diarrhoea - NOT malignant</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 9.</u> Month <u>19</u> Day <u> </u> Year <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>53</u> , to <u>Jan</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>59</u> , and that death occurred at <u>1:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D.				ADDRESS (Street, city or town, state) <u>Worton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u>				DATE SIGNED <u>1/13/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u>				ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>	
				24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

749

CERTIFICATE OF DEATH

00739

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home MFD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles David</u> Middle <u>Lewis</u> Last <u></u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1917</u>	9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>various</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Martha Harger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Naomi Miller</u> Address <u>Chestertown, Md. Sister</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 18</u> , 19 <u>59</u> , to <u>Jan 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>59</u> , and that death occurred at <u>10</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>1/20/59</u> ACTUAL SIGNATURE <u>E. D. Kester</u> M.D. <u></u> PHYSICIAN'S NAME (Type) <u>Eugene Kester</u> <u>Rock Hall, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pomona Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00740

750
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. LENGTH OF STAY IN 1b <u>15 YEARS</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>none</u>				d. STREET ADDRESS <u>Chesapeake Ave</u>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jacob</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26 1883</u>			
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>David Miller</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Steiner</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>202-01-0513</u>		17. INFORMANT Address <u>Adelaide Miller Rock Hall</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>181.0</u> DUE TO (b) <u>Arterio Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma of Bladder</u> DUE TO (c) <u>Carcinoma of Bladder</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>					
21. I certify that I attended the deceased from <u>Jan 2, 1957</u> to <u>Jan 10, 1959</u> , that I last saw the deceased alive on <u>Jan 9, 1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall Md</u> DATE SIGNED <u> </u>									
ACTUAL SIGNATURE <u>Robert C. Nitsch</u> M.D. <u>Rock Hall Md</u>				DATE SIGNED <u> </u>					
PHYSICIAN'S NAME (Type) <u>ROBERT-C. NITSCH</u>				DATE SIGNED <u> </u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 14</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Cedar Hills</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia PA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane - Church Hill, Md</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>			

CERTIFICATE OF DEATH

250

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1905</u></p>	
<p>5. Place of birth: <u>New York City</u></p>		<p>6. Date of death: <u>Dec 10, 1950</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>Dec 15, 1950</u></p>		<p>14. Office of registration: <u>Baltimore</u></p>	

RECEIVED
 JAN 15 1951
 BALTIMORE
 MARYLAND
 STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00741

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford <i>Balto</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond (rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco <i>038-2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4 miles from Still Pond			d. STREET ADDRESS Black Rock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) RICHARD JAY NEWMAN			4. DATE OF DEATH Month January Day 14 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1926		9. AGE (In years last birthday) 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Engineer copilot		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Irving Newman		
14. MOTHER'S MAIDEN NAME <i>Josephine Newman Stedley</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW2		
16. SOCIAL SECURITY NO. 216 22 8838			17. INFORMANT Thomas A. Brandt, Kingsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries -- fragmentation of body 863x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash			
20c. TIME OF INJURY Month, Day, Year 11:55 PM 1/14 1959		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20f. (City or town) Nr. Still Pond		20g. (County) Kent		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/15/59	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 17/59		22c. NAME OF CEMETERY OR CREMATORY Grace	
22d. LOCATION (City, town, or county) Balto Co Md		(State) Md		23. FUNERAL DIRECTOR'S SIGNATURE Edw S. Hipton	
24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
MEDICAL DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		X-RAY EXAMINATION		PATHOLOGICAL EXAMINATION	
TREATMENT		PROGNOSIS		FOLLOW-UP		REMARKS		SIGNATURE	

FOR STATE
HEALTH-DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00742

Reg. Dist. No.

752

1. PLACE OF DEATH a. COUNTY <u>Kent</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown RFD</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chestertown RFD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>At - Melotita</u>			d. STREET ADDRESS <u>Melotita</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Tempie</u> Middle <u>Norris</u> Last <u>Norris</u>			4. DATE OF DEATH Jan. <u>7</u> , 19 <u>59</u> Year <u>19</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/83</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Joseph Stewart</u>		
14. MOTHER'S MAIDEN NAME <u>Maria unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>don't know</u>			17. INFORMANT <u>Mrs. Marcia Wilson</u> Address <u>Chestertown, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown causes - probably natural</u> <u>795.3</u> DUE TO (b) <u>Found dead about 6³⁰ am - Had previously been in apparent good health - Had lab</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no medical attention</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <u>Robert W. Farr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/7/59</u>	
EXAMINER'S NAME (Type) <u>Robert W. Farr</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Melotita Cem</u>		22d. LOCATION (City, town, or county) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walley</u>		ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE
HEALTH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Medical Examiner	
11. Signature of Coroner		12. Signature of Registrar		13. Signature of Physician		14. Signature of Nurse		15. Signature of Undertaker	
16. Signature of Burial Director		17. Signature of Cemetery		18. Signature of Funeral Home		19. Signature of Mortician		20. Signature of Embalmer	
21. Signature of Transporter		22. Signature of Reinterment		23. Signature of Crematorium		24. Signature of Burial		25. Signature of Interment	
26. Signature of Disposition		27. Signature of Release		28. Signature of Transfer		29. Signature of Return		30. Signature of Receipt	
31. Signature of Acknowledgment		32. Signature of Consent		33. Signature of Assent		34. Signature of Dissent		35. Signature of Refusal	
36. Signature of Waiver		37. Signature of Release		38. Signature of Transfer		39. Signature of Return		40. Signature of Receipt	
41. Signature of Acknowledgment		42. Signature of Consent		43. Signature of Assent		44. Signature of Dissent		45. Signature of Refusal	
46. Signature of Waiver		47. Signature of Release		48. Signature of Transfer		49. Signature of Return		50. Signature of Receipt	
51. Signature of Acknowledgment		52. Signature of Consent		53. Signature of Assent		54. Signature of Dissent		55. Signature of Refusal	
56. Signature of Waiver		57. Signature of Release		58. Signature of Transfer		59. Signature of Return		60. Signature of Receipt	
61. Signature of Acknowledgment		62. Signature of Consent		63. Signature of Assent		64. Signature of Dissent		65. Signature of Refusal	
66. Signature of Waiver		67. Signature of Release		68. Signature of Transfer		69. Signature of Return		70. Signature of Receipt	
71. Signature of Acknowledgment		72. Signature of Consent		73. Signature of Assent		74. Signature of Dissent		75. Signature of Refusal	
76. Signature of Waiver		77. Signature of Release		78. Signature of Transfer		79. Signature of Return		80. Signature of Receipt	
81. Signature of Acknowledgment		82. Signature of Consent		83. Signature of Assent		84. Signature of Dissent		85. Signature of Refusal	
86. Signature of Waiver		87. Signature of Release		88. Signature of Transfer		89. Signature of Return		90. Signature of Receipt	
91. Signature of Acknowledgment		92. Signature of Consent		93. Signature of Assent		94. Signature of Dissent		95. Signature of Refusal	
96. Signature of Waiver		97. Signature of Release		98. Signature of Transfer		99. Signature of Return		100. Signature of Receipt	

753 CERTIFICATE OF DEATH

00743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FAIRFIELD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>96 Rock Major Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Perry</u> Middle <u>B</u> Last <u>Patterson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1908</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Remington Arms</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. S. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Stucky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-07-8026</u>	
17. INFORMANT <u>Edwin H Puck</u>		Address <u>1419 27th St NW DC.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall</u> DATE SIGNED <u>1/6/59</u> ACTUAL SIGNATURE <u>William H. Lintworth</u> M.D. PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-8-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) <u>Fairfield</u> (State) <u>Conn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar R Lane</u>		ADDRESS <u>Church Hill</u>	
24a. REC'D BY REGISTRAR <u>Jan 9 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Annes</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Merritt</u> Last <u>Seney</u>				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15, 1874</u>	9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Salisbury Seney</u>				14. MOTHER'S MAIDEN NAME <u>Frances Cecil</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>220-34-9937</u>		17. INFORMANT <u>Hospital records, Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>a few minutes</u> <u>Many years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene, right 4th toe, due to peripheral ischemia & arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/18/</u> 19 <u>58</u> , to <u>1/13/59</u> 19 <u> </u> , that I last saw the deceased alive on <u>1/13/59</u> 19 <u>59</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>1/13/59</u>							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				M.D. <u>Chestertown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 16</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
item 2 Film G237 1-19-59 et
754
CERTIFICATE OF DEATH

00745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Groves Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galena</u>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>D.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Smith</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Grubb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Groves Nursing Home</u>		Address <u>Kennedyville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile debility</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degeneration of the heart muscle</u> (c) <u>Nephrositis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 years</u> <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. p.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 27, 1958</u> to <u>Jan 8, 1959</u> , that I last saw the deceased alive on <u>Jan 7, 1959</u> , and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geza Koralewski</u>		ADDRESS (Street, city or town, state) <u>MILLINGTON, MD</u>	
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>		DATE SIGNED <u>1-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		ADDRESS <u>Still Pond, Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Antonia S. Finner</u>	

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CERTIFICATE OF DEATH

00746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Chestertown				c. LENGTH OF STAY IN 1b life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown R.D.3							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Trew Farm Quaker Neck				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lillie Middle May Last Trew				4. DATE OF DEATH Month Jan. Day 3 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1881	
9. AGE (In years for birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Wesley Hadaway				14. MOTHER'S MAIDEN NAME Margaret Copper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Wesley Trew Chestertown R.D. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) Cardio Vascular Diseases				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1958 , to Jan 3, 1959 , that I last saw the deceased alive on Jan 2, 1959 , and that death occurred at 6:49 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norbet C. Nitsch				ADDRESS (Street, city or town, state) Rock Hall, Md.			
PHYSICIAN'S NAME (Type) Norbet C. Nitsch				DATE SIGNED Jan 6 '59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/59		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md,		24a. REC'D BY REGISTRAR DATE JAN 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thoms			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00747

744 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 Queen St (South)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond First Yorker Middle Last		4. DATE OF DEATH Jan. 5, 1959 Month Day Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Yorker		14. MOTHER'S MAIDEN NAME Ellen unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 12-14-4307	
17. INFORMANT Louise Yorker Address Chestertown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arterio sclerotic cardio vascular disease IMMEDIATE CAUSE (a) 422.1 DUE TO Generalized Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) many years DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , to Jan. 5, 1959 , that I last saw the deceased alive on Jan. 5, 1959 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr M.D.		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/6/59	
PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Janes Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR JAN 7 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
MIDDLE NAME		BIRTH DATE		BIRTH PLACE		MARRIAGE DATE		MARRIAGE PLACE		OCCUPATION	
CAUSE OF DEATH		IMMEDIATE		INTERMEDIATE		FINAL		MANNER OF DEATH		CERTIFICATE NO.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	

RECEIVED
JAN 10 1918